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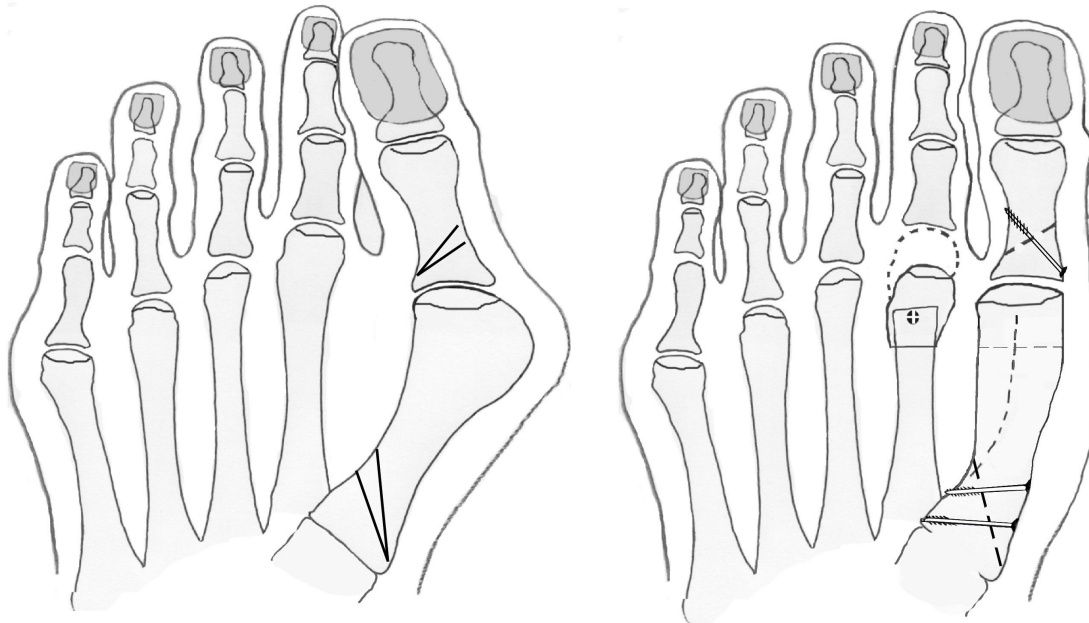
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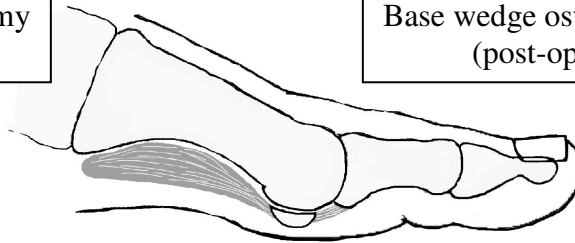
About Hallux Valgus and Your Operation Surgery by Base Wedge Osteotomy

P14



Base wedge osteotomy
(pre-op)

Base wedge osteotomy
(post-op)



*Your specialist may add
in any unique features
of your surgical
procedure on the above
diagram*

Hallux Valgus (Bunion) deformity occurs when the big toe joint becomes buckled and prominent. Excessive pressure may occur at the joint which becomes abraded by shoes and can often develop arthritis. The joint may often become difficult to move in its correct position and is often painful on the inner side and outer side.

The cause of hallux valgus deformity is complex and multi-factorial. Footwear certainly plays a role as an exacerbating factor and possibly serves to enhance the progression of the deformity. However, it is known that hallux valgus occurs in unshod cultures although, in one study in Chinese Hong Kong,

hallux valgus was 70 times more common among shoe-wearers compared with the unshod members of the same community. There is a familial (hereditary) incidence of around 65-80% with genetic predisposition being highly significant; however, successive generations won't always produce the deformity.

Other general conditions play a part also, for example, joint laxity (hypermobility) is more common in the hallux valgus patient. Conditions such as Marfan's and Ehlers-Danlos syndrome can produce remarkable joint laxity resulting in unstable and marked hallux valgus. This "splay foot" type is also seen in the more elderly patient where weak muscles cause instability of the toes, as does rheumatoid arthritis. Other alleged biomechanical factors such as tarsometatarsal (midfoot) instability due to flat-footedness (over-pronation), may also play a part, but remain unproven.

Conservative (non-surgical) Treatment

Medical evidence has demonstrated that this deformity can only be reversed or corrected by surgery. However, some treatments are sometimes provided that can help relieve the *symptoms* caused by a malaligned big-toe joint. If the joint is very inflamed, an injection of cortisone (steroid) helps to temporarily reduce pain and inflammation in around 50% of cases. Changing your footwear to accommodate the wider forefoot, can also help to reduce pressure on the joint. Some clinicians believe in prescribing orthoses (insoles) for hallux valgus, although one large PhD study found that the orthoses made the problem worse in children. Toe splints have been used and studied, however, mild improvement was only seen in some children.

In the early stages, medication, shoe changes and insoles may help for a short period of time. Often the only effective treatment is operative care. This is built on years of research and experience and is aimed at both re-aligning the joint in addition to relieving the symptoms.

Most of the operations involve making precise cuts in the bone to shift the joint into a more corrected alignment. The bone is held by small wires, screws or plates. The foot may be placed in a special bandage or cast to protect it. You will be required to completely non-weight-bear for a number of weeks (up to 8), using crutches. Barring complications such as slow bone healing, you will be allowed to fully weight-bear from 4-8 weeks after surgery, but determined on an individual basis. At this stage we recommend you wear a trainer or tennis shoe or if the swelling is marked, a sport sandal may be used (e.g. Teva or Merrill).

Bunion surgery is usually very successful with the majority of patients experiencing a significant improvement in their foot condition, but post-operative swelling is **normal** and will persist for many months following surgery.

Basal Osteotomy

Answers to Common Questions

The following is general advice and may be altered according to your needs

The Operation

The operation is performed under local anaesthetic with sedation or general anaesthetic. The operation takes about an hour, although you will be in the Hospital for the afternoon, to allow you an opportunity to rest post operatively. You must have a competent adult at home for the first day and night after surgery. This allows us to be sure you will be safe for the first night. You may be relatively incapacitated for up to 8 weeks and it is important that you allow for this and arrange suitable home support.

The First 3 Days after Surgery

You will have a cast on the foot which had surgery and you should not place this foot to the floor. You will be move about using the crutches or frame provided, but you must rest, with your feet up, as much as possible. You should restrict your movements to going to the bathroom and when getting about use your crutches/frame in the way you will have been shown.

After 10 Days

Between 10 and 14 days your stitches will be removed (although this may not be necessary if the stitches are absorbable). Your cast will be with a new lightweight resin cast or removable boot, after dressing change and wound inspection. You should continue to be careful and use your crutches, you are still not allowed to put any weight on the foot which had surgery – for the first 4 weeks.

Between 4-8 Weeks

At 4 weeks you can put gentle weight through the foot – you will still be in a cast or may be issued a removable walker boot. At 6 to 8 weeks you will have an appointment to check on progress, at this stage it is usual to remove the cast/walker boot and gradually start placing full weight on the foot. You should wear a trainer type shoe for support and to contain swelling. You will be given exercises you are required to carry out. X-rays will have been arranged and this allows us to check on progress. Physiotherapy is sometimes arranged at around 12 weeks but this is on an individual basis.

After 6-months

The foot will be gradually returning to normal and the majority of patients will be back in a full range of normal footwear. Although the foot may now be comfortable and returning to normal, there may still be residual swelling, particularly towards the end of the day. This is normal, as feet and legs are very prone to swelling anyway. Your foot will still ache from time to time as the bones need to 'settle down' somewhat.

12 Months after Surgery

By this stage the foot should be getting more comfortable now and you should be back to normal shoes with only occasional minor discomfort.

Return to work

At any time from 8-12 weeks you may return to work (depending on your work and the type of footwear in which you are allowed to return to work). Obviously other factors such as; the severity of the deformity, tissue quality, circulation and general health can also make a difference.

Potential Risks and Complications

This information is provided so that you can make an informed decision over your treatment; it is not designed to frighten you as it should be remembered that the overwhelming majority of our procedures are very successful and all complications are treatable. Your surgery carries the following *unlikely* but *possible* complications:

Infection, (approximately 2% risk). The vast majority of these are soft-tissue infections, treatable by antibiotic tablets as an outpatient. Bone infections are very uncommon, but would require hospital admittance for treatment.

Severe pain only occurs in around 7% of cases in the first 24 hour period. We use a combination of local anaesthetic techniques and compound analgesics, which is usually very effective. Rarely, patients can develop Complex Regional Pain Syndrome (cause unknown), this is where the nervous system dealing with pain over reacts in a prolonged manner often to a minor incident and requires specialist treatment at a pain clinic. This condition doesn't always resolve.

Swelling is common to all surgery and may take 4-6 months or longer to reduce.

Approximately 20% of cases need to have fixation (bone screws, plates and pins) removed: although this is not actually a complication, it needs to be born in mind.

Recurrence of deformity is uncommon (~ 5%), but remains a possibility; as does over or under correction. 7% of patients can suffer a non-union which would require a longer period in a plaster cast or revision surgery. Smoking may increase your risk of the surgical fracture not healing by up to 3 times that of a non-smoker.

Vein clots can occur with any lower limb surgery, but in our practice they are seen in less than 1 in 200 cases (compared with general orthopaedics where the occurrence is reported as high as 4 out of 10 cases). Vein clots, or Deep Vein Thrombosis (DVT), is more common in elderly patients, diabetics, obese patients and patients where two or more immediate family members have suffered DVT, stroke or heart attack. If we suspect a DVT we will arrange appropriate tests and scans and if positive, you will be treated as an outpatient, with a period on Warfarin anticoagulant therapy.

Stiffness of the big toe joint can occur following surgery. It may be a consequence of arthritis changes within the joint, scarring or damage to the joint surfaces. In order to try and prevent this complication it is important that you carry out the exercises that you are advised post surgery. Treatment of this complication may require manipulation under anaesthetic following your initial surgery.

Weak or elevation of toe. Weakness of the tendons beneath the big toe joint can occur following surgery. This complication can be improved by the exercises you are shown post surgery.

Fracture following surgery is a possibility. This is often treated by putting your foot into a cast for 6-8 weeks. Generally these fractures heal uneventfully but occasionally if there is a change in the position of the bone or the fracture fails to heal, further surgery may be required.

Haematoma – a painful accumulation of blood at the surgery site, which may result in delayed wound healing and increased infection risk. This is rare complication in our practice (around 1:2000 procedures). A wound wash-out under anaesthetic may prove necessary.

Adverse reaction to the post operative pain killers. 1 in 50 patients, for example, report that the Codeine preparations make them feel sick.

Research shows that 0.03% of patients may suffer from circulatory impairment with tissue loss

Occasionally, following this surgery, you may have some increase of pressure under the joints next to the big toe joints (transfer metatarsalgia); this is treatable, although surgical treatment may be necessary to shorten one or more of the adjacent metatarsal bones, to relieve the pressure.

Unsightly scarring (hypertrophic or keloid) is possible and is more common in Afro-Caribbean; Middle and far-Eastern skin-types. Scarring can be reduced by starting to use – 3 weeks after surgery – Boots scar reduction pads or Cica care pads. Use of for example, Bio Oil, at 4 weeks onwards, vigorously massaged into and across the scar, is helpful. At 6 weeks following surgery, you may wish to use a hydrocortisone cream to massage vigorously along the scarline twice a day for 2-weeks e.g. HC45 cream; but only if the scar is raised and reddened.

Recurrence or failure of surgery: there is no absolute guarantee that your surgery will be a success. Usually we talk in terms of percentage improvement. The problem/s that you have means your foot is no longer normal. It is certainly not normal to have surgery and therefore your foot cannot ever be normal again. Your Consultant has performed over 8000 foot and ankle procedures, and it is our hope that these experiences and skills will help to rectify your current foot problems. Occasionally, patients do not do well from surgery, for a variety of reasons, often outside of the control of the surgeon or the patient. Very rarely a patient may be left worse off after surgery; although this is extremely uncommon. In these cases further (revision) surgery may prove necessary.

Please bring this slip with you, pre-signed on the day of your procedure.

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Declaration: I have read and understood all the information in this leaflet (P14)

Full name: _____

Signature: _____ Date: ____/____/____

Patient Parent Guardian